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Relevant Remarks of Ms. Patricia Schultheiss
Bureau of Competition
Federal Trade Commission
Regarding July 2004 Joint FTC/DOJ Report Titled:
"Improving Health Care: A Dose of Competition."
Presented at the Annual Meeting of
The Georgia Alliance of Community Hospitals
October 2004

Charles Hayslett's introduction of Ms. Schultheiss: Our next speaker is Patricia Schultheiss. She is an attorney with the FTC. She – most specifically to today's purpose – she helped write three chapters, or wrote three chapters, of a report that many of you have seen, called – it came out jointly from the Department of Justice and the Federal Trade Commission – called "Improving Health Care -- A Dose of Competition," and she wrote, again, three chapters, including the one on hospital competition.

Patricia Schultheiss: This is the cover of our report: *Improving Health Care: A Dose of Competition*, and it was issued in July of this year.

So, what I'd like to do is just run through very quickly what the report says, and then open it up for questions at that point, and then we can go back to some of the other issues if time permits.

The report overview is that we have an executive summary and eight chapters.

And then, finally, miscellaneous.

And miscellaneous is, perhaps, in some ways very interesting – of great interest to you because that's the chapter where certificate of need issue is discussed, and quite frankly, there's only the five pages of a 400 page report that actually deals with certificate of need. So, it isn't the only thing that's talked about in the report.

Let me just say one other thing about the report because I think there's a misconception that this might be a study or something like that. It is not a formal study; it's not an empirical study.

We have certain positions when it relates directly to the competition law, but for example... and I'll get into a little bit.... On certificate of need, there are people that thought certificate of need improves quality and lowers costs in the states where it exists and cited studies to that.

We also talk about specialty hospitals and ambulatory surgery centers, and we will come back to that.

Frequently the single specialty hospitals will focus on areas like cardiac and orthopedic surgery, and we've heard, obviously, from a number of folks during the hearings and in research that there is some concern that the areas where the single specialty hospitals are going into like cardiac and orthopedic tend to be some of the more profitable areas of surgery for community hospitals and that affects cross-subsidy – the ability to cross-subsidize the uninsured and emergency care and trauma care and things like that so there is an awareness of these issues.

And as some of you may know, Congress has imposed a moratorium on Medicare payments and mandated studies of single specialty hospitals in terms of whether they're taking their share of Medicare/Medicaid patients, what kind of self-dealing, what kind of profit motivation, what it's impact might be on community hospitals.

Medpac, which is the medical advisory board to Congress on payment issues, is the one directed to conduct this study.

Okay, single specialty hospitals. One way that this - the competing perspectives have been reported is as follows: advocates of these hospitals contend that the focused mission and the dedicated resources of specialty hospitals both improve quality and reduce cost. Critics contend that specialty hospitals siphon off the most profitable procedures and patient cases, thus eroding the financial health of neighboring general hospitals and impairing their ability to provide emergency care and other essential community services.

And there is a somewhat related issue – that is the issue of ambulatory surgical centers. And, obviously, they perform surgery on patients that don't require an overnight stay. About one-half of them are single specialty – often gastroenterology, orthopedics or ophthalmology. Most of them have 2-4 operating rooms, and their ownership structure varies. Some are physician owned, some are joint ventures between physicians and publicly or privately traded companies, some are joint physician/hospital ventures and some are completely owned by hospital or hospital networks. There are over 3,000 ambulatory surgical centers currently. Most of them do not have emergency departments. Depending on state certificate of need, regulations may or may not apply. And if they apply, sometimes they are less rigorous for an ambulatory surgical center as opposed to a full-fledged hospital, and obviously, they do compete with hospital outpatient surgery units.

Those that support the growth of ambulatory surgical centers attribute the growth to improved technology, physician demand for efficient surgical

facilities, control and specialized staff, and again, that's actually an issue that is being looked at by MEDPAC in connection with the study that they're doing for Congress.

And one of the issues that we saw as we were looking at ambulatory surgical centers and were doing research was that Medicare reimbursement - at least from '82-'88 - provided 100 percent of their covered cost, basically. So in essence, the payment policies of Medicare were promoting the growth of these surgical centers without, perhaps, looking at all the issues involved and how it impacted upon community hospitals or other outpatient surgical centers that were in any given community. However, they had - in '88 they did use basically a fee schedule – but again, when we looked at this issue, there was some sense that the government's own payment policies may be skewing how some of the growth did occur.

Now those that oppose ambulatory surgical centers are concerned that they erode hospital outpatient market share, they don't care for Medicaid beneficiaries and they skim and cherry-pick some of the issues I've already talked about.

And, now for the FTC/DOJ perspective... Obviously, we favor the elimination of anti-competitive barriers to entry. And there is a recommendation in our report - which will come up in a minute - about certificate of need. Single specialty hospitals and ambulatory surgical centers, we believe based on the information we have reviewed, have had some beneficial consequences for consumers. Nonetheless, we also recognize that Medicare's administrative pricing has contributed to the growth of these entities and, perhaps, not necessarily in an even-handed way, so there is a recognition of that.

Nonetheless, observation #9 - as I said there were eleven observations and six recommendations - observation #9 in the FTC/DOJ report states that private parties should not engage in anticompetitive conduct in responding to marketplace developments. That's, I guess, a little amorphous. Antitrust law is kind of - a bit of - a gray area.

One of the six recommendations in the report is really specific to certificate of need, basically saying that the state should decrease barriers to entry into provider markets. Know, however, it doesn't say that you should get rid of certificate of need. It doesn't say you should completely eliminate it. What the report – what we were really trying to do – and if you look at the text - is say that there are ways in which it can be used to harm competition, to harm consumers, to increase costs and maybe harm quality. There may also be areas where it can be used appropriately to keep the market appropriately competitive and also to improve quality. So it doesn't – the report does not come down and say certificate of need has no place.

Yes... *(Addressing audience member)*

Q: [Inaudible question from audience.]

Ms. Schultheiss: But the other thing you have to realize -- at least about the FTC – the FTC has actually been pretty active in the certificate of need area for quite a lot of years – going back to the '80's and looking at certificate of need statues and their impact on competition. And so, it's not, given history and the studies that have been done over the course of a number of years by various economists at the FTC, it's not completely surprising that that is at least a recommendation. But it doesn't, as I said - it doesn't tell states that they should absolutely eliminate certificate of need. A lot of the recommendations are fairly soft recommendations. In a sense of really trying to get policymakers to just think about these issues as they go about making decisions. But you're right; it's five pages out of a 400-page report.

Q: [Partly inaudible question how audience dealing with uncompensated care.] "Is that addressed in the report anywhere?"

A: Ms. Schultheiss: And I think that one of the big concerns, and I will say at least from my perspective and from my understanding of other folks at the FTC, is that the payment systems are so skewed. It shouldn't be that you have to subsidize your uninsured or underinsured care through these other areas. I mean there should be appropriate reimbursement – for your burn units, for your trauma units, for all of those areas.

Q: [Partly inaudible comment from the audience]. "... but that's not the reality."

A: Ms. Schultheiss: Right, and I think there is an understanding of that, and that's why, in a lot of ways, the report doesn't really say you can never engage in using certificate of need.

Q: [Mostly inaudible comment/question from audience]: This is "not the reality we are faced with on a daily basis..."

A: Ms. Schultheiss: None of these things can really be taken in a vacuum. There are obviously – we want to promote – we would like to see more competition. We would like to see more of the market forces working in the health care industry than work there right now. But we recognize that you do not have perfect competition in the health care network because consumers – the ultimate - the people that are purchasing the services do not pay for them. And whenever you have that – you sort of turn economic principle onto its head.

I think from an antitrust agency perspective, we do tend to look at it in increments, and that is, for better or worse, the way the antitrust agencies do look at these things and to the extent that they do, you have to be aware

of not running afoul of the antitrust laws, but there is that – there is a true problem with the fact that there are so many issues in the health care industry. And there isn't perfect competition at this standpoint – at this point in time - and it is difficult.

Q: [From audience member Andy Galloway]: "I was happy to see that there is some understanding, at least, at the FTC that health care economics do not conform to traditional economics. And of course, you are correct. I'm curious. In your world, how would you provide the things for which there is essentially little or virtually no competition? Like caring for the uninsured, neo-natal, ICUs, medical education? How would you provide for these?"

A: Ms. Schultheiss: I think the answer – I mean, I think the thing is that – you have to provide adequate insurance – I mean, you can't provide for it without some kind of core subsidy right now. It's almost impossible. It just is. And actually, my recollection is that the report also talks a little bit about medical education and varying reimbursement schemes that go into trying to help compensate for residency programs and training programs at hospitals, but a lot of that is borne by the hospitals themselves as well.

Having worked at the FTC on and off, however, for 25 years, I know that we attempt to try to instill or infuse competition where possible. 'Cause the belief is that ultimately consumers are the beneficiaries of that. But we also recognize, and I think it's clear in this report, that there are a lot of pressures. And particularly on hospitals in terms of how do they survive in the current environment – and the current reimbursement environment? And uninsured environment? So it's - I don't really have an answer, I'm afraid.

In fact, presented during the hearings, in specifically, in terms of certificate of need - the June 10th hearing transcript which is on the Web site, somebody by the name of Piper Hennessey, I think it was, there was one other person – it's escaping me, but Piper actually works for, I think it's the American Health Planning Association, and he spoke to three studies that were done by the automobile manufacturers who have, obviously, huge amounts - numbers of employees and retirees who are insured - for health insurance. And they did studies looking at their costs in states that had certificate of need and in states that did not. And at least, according to how those studies were represented at the hearings, those studies showed that the costs were lower in states that had certificate of need.

So maybe it's being appropriately used in a state like Georgia where you show that your quality is fine, your costs are lower – your prices are lower. And the certificate of need process is actually working as it was originally meant to work.

If it's something that comes up, I think you would want to look at the transcript of June 10th of 2003 for information that goes to both sides of the issue in a very thorough way. If that's an issue of concern to you I think it

would be worth reading that particular transcript. It's not – it's about 150 pages or something. And it does – and there are only, I think, three or four speakers that address certificate of need in this transcript. They talk about a number of other things, but I would commend that as background information to you and, I think, it's Tom Piper's testimony in particular, and his presentations that were submitted as supplementary material, and that's all on our Web site.

Q: [Inaudible question from audience]:

A: Ms. Schultheiss: Care of indigents? That is addressed in various aspects of the report. I think that the report does touch on those issues. Whether or not it actually brings it together or not, I can't say. I don't know that it does.

Q: [Inaudible question from audience]:

A: Ms. Schultheiss: No, the uninsured is dealt with in the insurance chapter.

Well, thank you, and thank you for your questions and comments.